Prudential Financial

GROUP LIFE ENROLLMENT/CHANGE CARD

The Prudential Insurance Company of America

Please refer to the description of your plan for coverage options and amounts available to you.

Employee's Last Name	First Name	MI	Name of Employer	Group Policy No.	Claim Branch

Employee's Address	Employee's Annual Salary $

Social Security No. - -	Date of Birth / /	Date Employed / /	❑ Married ❑ Single	❑ Widowed ❑ Divorced	❑ Male ❑ Female

Please mark the appropriate box according to your plan.

Type of Coverage	❑ Basic Term Life (Non Contrib.)	❑ Optional Term Life	❑ Dependent Term Life	❑ Accidental Death & Dismemberment (Non Contrib.)	❑ Optional Accidental Death & Dismemberment
Enter Amount					
Effective Date					

EMPLOYEE'S DEPENDENT INFORMATION

Dependent's Last Name	First Name	MI	Date of Birth	Relationship to Employee
			/ /	
			/ /	
			/ /	

My Dependent coverage is for: ❑ Spouse Only ❑ Spouse & Children

MY BENEFICIARY'S NAME (PLEASE PRINT) Example: Mary A. Doe, not Mrs. J. Doe

_____

First Name Middle Initial Last Name Relationship To Employee

_____

Address

_____

First Name Middle Initial Last Name Relationship To Employee

_____

Address

_____

First Name Middle Initial Last Name Relationship To Employee

_____

Address

If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

EMPLOYEE'S SIGNATURE

❑ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. I declare the statement above is true and understand it is the basis for determining the monthly contribution for coverage.

❑ I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents.

Employee Signature _____ Date (Month/Day/Year)_____ / _____ / _____

IMPORTANT NOTICE

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

NEW JERSEY RESIDENTS - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FOR EMPLOYER'S USE ONLY

CHANGES OF BENEFICIARY

DATE OF CHANGE	NEW BENEFICIARY DESIGNATED	RELATIONSHIP

ADDITIONAL INFORMATION:

CHANGED AMOUNT OF INSURANCE

COVERAGE	CHANGE 1		CHANGE 2		CHANGE 3		CHANGE 4		CHANGE 5	
	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount
BASIC TERM LIFE										
OPT. TERM LIFE										
BASIC AD&D										
OPT. AD&D										
DEPENDENT TERM LIFE										

NEW YORK: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

Basic Term Life, Dependent Term Life, Optional Term Life, and Basic and Optional Accidental Death & Dismemberment coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Prudential Financial is a service mark of The Prudential Insurance Company, USA and its affiliates. The Accidental Death & Dismemberment phone number is: 800-524-0542. Please refer to the Booklet-Certificate for all plan details, including any exclusions, limitations, and restrictions which may apply. Contract series: 83500.

The Prudential Insurance Company of America is a Prudential Financial company.